The Secretary for Health Services
COMMONWEALTH OF KENTUCKY
275 EAST MAIN STREET
FRANKFORT 40621-0001
(502) 564-7042

PAUL E. PATTON
GOVERNOR

MARCIA R. MORGAN
SECRETARY

March 5, 2003

Durable Medical Equipment Provider Letter # A-26
Pharmacy Provider Letter #A-459

Dear Provider:

Effective for dates of service on or after April 1, 2003, the Department for Medicaid Services, is changing its method for reimbursing pharmacy and durable medical equipment providers for Medicare Part B coinsurance and deductibles. Under this new pricing system, providers will not receive more from Medicaid for a Medicare Part B crossover claim for a given covered service than would be allowed for a Medicaid recipient for the same covered service. This change follows the lead of a majority of other states and has already been implemented in Kentucky for the majority of other Medicare Part A and Part B providers.

Section 1902(n) of the Social Security Act, as amended by the Balanced Budget Act of 1997, permits states to choose to continue to pay the full Medicare deductibles and coinsurance amounts for recipients eligible for both Medicare and Medicaid or to limit payment to the amounts established in their State Plan for the service. The law further states that providers must consider these payment amounts as payment in full. Recipients are not liable for any additional charges billed by medical providers.

Historically, the Kentucky Medicaid Program has paid the full amount of deductibles and coinsurance for services covered by Medicare. This results in higher payments being made for services for Medicare eligibles than for the same services for Medicaid eligible individuals. The new methodology, often called "repricing" will permit Medicaid to bring payments made on behalf of Medicare beneficiaries into

alignment with those made for other Medicaid eligibles. It will also permit Medicaid to redirect financial resources to address our significant budget shortfall.

Medicare Part B claims submitted by Pharmacy providers (Provider Type 54), and Durable Medical Equipment providers (Provider Type 90) on or after April 1, 2003 will be repriced under the new system. Medicaid payment will be the lesser of the Medicaid allowed amount minus the Medicare payment; or the amount of Medicare coinsurance and deductible, up to the Medicaid allowed amount.

The enclosed question and answer document will provide more detailed explanation and clarification of the new repricing methodology. If additional information is needed, please contact Duane Dringenburg, of the Physician and Specialty Services Division at 502-564-5969.

Sincerely,

Marcia R. Morgan
Secretary

Enclosure

Most Frequently Asked Questions Regarding
Changes to Medicare Crossover Payment Methodology

Why is the Department making this change?

The Department for Medicaid Services (DMS) is facing a situation in which expenditures are dramatically exceeding the budget forecast. The projected annual savings from this "Medicare repricing" change are significant and will help address budget constraints in a fiscally-responsible way that helps equalize payments for all Medicaid recipients and has been employed by a majority of states.

How is this different from the way you are currently paying crossovers?

Currently, DMS pays the full coinsurance and deductible for Medicare Part B Durable Medical Equipment services. On of September 1, 2002, repricing was implemented for Medicare Part A crossover claims. On February 1, 2003, repricing was implemented for the majority of Medicare Part B services. Under repricing, payment is made at the lesser of the Medicaid allowed amount minus the Medicare payment or the amount of Medicare coinsurance and deductible, up to the Medicaid allowed amount. Using this methodology for durable medical equipment and pharmacy services provided under Medicare Part B, Medicaid will now compare the Medicare-paid amount on the claim to the Medicaid allowed amount. If Medicare paid up to or more than the Medicaid allowed amount, no additional payment will be made. If Medicare paid less than the Medicaid allowed amount, Medicaid will reimburse the difference between the Medicaid allowed amount and the Medicare payment not to exceed the deductibles and coinsurance amounts

For example:

Medicare pays more than Medicaid Allowed Amount
Provider bills $500 to Medicare
Medicare allows $400 on the claim; $320 for the Medicare payments and $80 for the coinsurance
Medicaid allowed amount for this same service is $300
Medicaid would make no payment on the claim since Medicare's payment of $320 is more than the Medicaid allowed amount

Medicare pays nothing on the claim because the beneficiary is in their deductible period
Provider bills $100 to Medicare
Medicare allows $80 on the claim; $80 was the deductible amount and the Medicare payment was $0
Medicaid allowed amount for this same service is $60
Medicaid would pay $60 or the Medicaid allowed amount

Medicare pays less than the Medicaid Allowed Amount
Provider bills $500 to Medicare
Medicare allows $400 on the claim; $320 for the Medicare payment and $80 for coinsurance
Medicaid allowed payment for this same service is $350
Medicaid would pay $30 (the difference between the Medicaid allowed amount and the Medicare payment: ($350 - $320 = $30)

Will I need to bill every claim for dually eligible and qualified Medicare beneficiaries (QMBs) to both Medicare and Medicaid?

The Department estimates that a significant portion of claims billed to Medicare are reimbursed by Medicare at an amount equal to or greater than the Medicaid allowed amount. Providers may continue to bill Medicaid for those claims that will generate additional payment up to the Medicaid allowed amount. If you are uncertain, you can continue to bill all claims to Medicaid. Remember that Medicare must be billed first for services that are considered for payment by Medicare and Medicaid.

Can I bill the Medicaid beneficiary for the difference between the Medicare allowed amount and the payment made by Medicare and Medicaid on the claim?

No. Pursuant to federal regulations, Section 1902 (a)(25)(C) of the Social Security Act, if the provider accepts the patient as a Medicaid patient, coinsurance, deductibles, and other cost sharing responsibilities may not be billed to the Medicaid recipient, recipient's family, guardian or legal representative.

When is this change effective?

It is effective with services provided on or after April 1, 2002.

What providers will be impacted by this change?

Durable Medical Equipment providers (provider Type 90) and Pharmacies (provider type 54) will be affected by this latest change. This change was previously implemented for the majority of other Medicare Part A and Part B providers.